EXHIBIT 8
DATE 2/20/2013
HB 505

MEMORANDUM

TO: House Judiciary Committee

FROM: Bradley Williams, President,
Montanans Against Assisted Suicide

WRITTEN BY: Margaret Dore, Esq.

RE: Yes on HB 505 ("Aiding or Soliciting Suicide")

HEARING: February 20, 2013 at 8 am

DATE: February 19, 2013

INDEX

I. INTRODUCTION

This memo supports HB 505, a short and simple bill that clarifies the offense of aiding or soliciting suicide.[1] The bill's purpose is to close the door on efforts to legalize physician-assisted suicide.

The memo also presents a short history of the law of assisted suicide in Montana and discusses potential constitutional issues. This memo discusses how HB 505 works and why it should be passed.

II. FACTUAL AND LEGAL BACKGROUND

A. Physician-assisted Suicide

The American Medical Association (AMA) defines physician-assisted suicide as occurring "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."[2] An example would be a doctor's prescription for a lethal dose to facilitate a patient's suicide.[3] The AMA rejects this practice, stating:

> Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal

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[1] A copy of HB 505 is attached hereto in the appendix at A-1 & A-2.

[2] AMA Code of Medical Ethics, Opinion 2.211, available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page#

[3] Id.

risks.[4]

B. Most States Reject Assisted Suicide

In the last two years, three states have strengthened their laws against assisted suicide: Idaho; Georgia; and Louisiana.[5] There are just two states where physician-assisted suicide is legal: Oregon and Washington.[6]

On February 13, 2013, SB 220, a bill modeled on the Oregon and Washington acts was tabled in the Senate Judiciary Committee. In 2011, a similar bill was defeated in that same Committee.[7]

C. Patients are Not Necessarily Dying

In Oregon and Washington, physician-assisted suicide is legal for "terminal" patients, meaning patients predicted to have less than six months to live.[8] Such predictions can, however, be wrong.[9] Moreover, treatment can lead to recovery.

Consider, for example, Oregon resident Jeanette Hall who was

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[4] Id.

[5] See Margaret Dore, "US Overview," updated July 30, 2012, at http://www.choiceillusion.org/p/us-overview.html

[6] These laws were enacted as ballot initiatives. They can be viewed at ORS § 127.800-995 and RCW § 70.245.010-904.

[7] SB 167 was defeated on February 10, 2011.

[8] ORS 127.800 §.1.01(12); RCW 70.242.010(13).

[9] See Shapiro, Nina, *Terminal Uncertainty — Washington's new 'Death with Dignity' law allows doctors to help people commit suicide — once they've determined that the patient has only six months to live. But what if they're wrong?*, Seattle Weekly, January 14, 2009, *available at* www.seattleweekly.com/2009-01-14/news/terminal-uncertainty (Attached at A-3).

diagnosed with cancer and wanted to do assisted suicide.[10] Her doctor convinced her to be treated instead.[11] In a recent affidavit, she states:

> This July, it was 12 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.[12]

D. Problems with Legal Assisted Suicide

Problems with legal assisted suicide include that patients such as Ms. Hall are encouraged to throw away their lives. Another problem is financial elder abuse. Alex Schadenberg, Executive Director of the Euthanasia Prevention Coalition, states:

> A 2009 report by MetLife Mature Market Institute describes elder financial abuse as a crime "growing in intensity." See www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf, p.16. The perpetrators are often family members, some of whom feel themselves "entitled" to the elder's assets. (*Id.*, pp. 13-14). The report states that they start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or coercing elders to sign over the deeds to their homes, change their wills, or liquidate their assets. (*Id.*, p. 14). The report also states that victims "may even be murdered" by perpetrators. (*Id.*, p. 24).

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[10] See Affidavit of Jeanette Hall Opposing Assisted Suicide, August 17, 2012 (Attached at A-9); and Affidavit of Kenneth R. Stevens, JR., MD, September 18, 2012, ¶¶ 3-6). (Attached at A-11).

[11] Id.

[12] Affidavit of Jeanette Hall, ¶ 4. (Attached at A-10)

> With assisted suicide laws in Washington and Oregon, perpetrators can instead take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. Even if a patient struggled, "who would know?"[13]

III. A SHORT HISTORY OF ASSISTED SUICIDE IN MONTANA

A. Assisted Suicide

In 1895, the Montana Legislature enacted a criminal statute prohibiting assisted suicide as a "crime against the public safety."[14] In 1907, 1921 and 1947, this statute was re-codified, but its text remained unchanged.[15] The statute stated:

> Every person who deliberately aids, or advises or encourages another to commit suicide is guilty of a felony.[16]

B. The Constitutional Convention

In 1972, Montana held its constitutional convention. At that time, the convention's Bill of Rights Committee considered and rejected a proposed "right to die."[17] The testimony

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[13] Alex Schadenberg, Letter to the Editor, "Elder Abuse a Growing Problem," *The Advocate*, the official publication of the Idaho State Bar, October 2010, http://www.margaretdore.com/info/october_Letters.pdf

[14] Section 698, Pen. C. 1895.

[15] In 1907, § 698, Pen. C. 1895 was reenacted as § 8529, Rev. C. 1907. In 1921, the statute was reenacted as § 11261, R.C.M. In 1947, the statute was reenacted as § 94-35-215.

[16] Id.

[17] See Margaret Dore, "Montana Constitution Does Not Include a 'Right to Die,'" Montanans Against Assisted Suicide, updated January 20, 2013, at www.montanansagainstassistedsuicide.org/p/no-right-to-die.html (Attached at A-18)

supporting this proposal had included an argument to allow physician-assisted suicide in the case of a painful death.[18]

On June 6, 1972, the new Montana State Constitution was ratified by the people without the proposed right to die.[19] This is the present Constitution of the State of Montana.[20]

C. A New Criminal Code

In 1973, the Legislature enacted a new criminal code drafted by the Criminal Law Commission. The new Code moved the prohibition against aiding a suicide to the homicide statutes.[21] If the suicide occurred, the offense would be homicide.[22] If the suicide did not occur, the offense would be "aiding or soliciting suicide."[23] The Criminal Law Commission Comments stated that a victim's consent was not a defense, as follows:

> If the conduct of the offender made him the agent of the death, the offense is criminal homicide, *notwithstanding the consent or even the solicitations of the victim.* (Emphasis added)[24]

The new Code did not, however, provide this clarifying

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[18] Id.

[19] Id.

[20] Id.

[21] See Table of Contents attached hereto at A-21.

[22] See Montana Legislative Services Division, *2012 Annotations to the Montana Code Annotated*, p. 271 (Annotator's Note regarding 45-5-105, MCA).

[23] 45-5-105(1), MCA.

[24] Criminal Law Commission Comments regarding 45-5-105, MCA. (Attached hereto at A-22)

information in the statutes themselves.

In 1981, the Legislature added a monetary penalty.[25]

D. Civil Liability

In 1989, the Supreme Court of Montana issued *Krieg v. Massey*, describing that civil liability can be imposed against a person who causes or fails to prevent another person's suicide.[26]

E. *Baxter v. State*

On December 8, 2008, a district court judge issued a decision holding that there is a right to physician-assisted suicide under the Montana State Constitution.[27] On December 31, 2009, the Supreme Court of Montana vacated this decision in *Baxter v. State*.[28] The vote to vacate was six justices to one.[29]

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[25] See 45-5-105(2).

[26] *Krieg*, 239 Mont. 469, 472-3 (1989) states:

> The general rule . . . is that "[n]egligence actions for the suicide of another will generally not lie since the act or suicide is considered a deliberate intervening act exonerating the defendant from legal responsibility . . .
>
> There are two . . . exceptions to this rule. The first exception deals with causing another to commit suicide . . . The second exception allows the imposition of a duty to prevent suicide but only in a custodial situation where suicide is foreseeable. These situations typically involve hospitals or prisons.

[27] *Baxter v. State.*, 354 Mont. 234, ¶¶ 7 & 9, 224 P.3d 1211, 2009 MT 449,

[28] Id., ¶ 51

[29] In *Baxter*, Justice James Nelson, specially concurring, was the only justice who voted to affirm a constitutional right to physician-assisted suicide under the Montana State Constitution. See his concurrence beginning at ¶ 64. The majority opinion issued by Justice William Leaphart vacated the district court's constitutional ruling at ¶ 51 ("The District Court's ruling

In *Baxter*, the Supreme Court also held that a patient's consent to assisted suicide is a defense to a homicide charge against an assisting physician.[30] When making this holding, the Court said that it was not bound by the Criminal Law Commission Comments, providing that a victim cannot consent, because the language of the Comments did not appear in the statutes themselves.[31] Again, the Criminal Law Commission Comments state:

> If the conduct of the offender made him the agent of the death, the offense is criminal homicide, *notwithstanding the consent or even the solicitations of the victim.* (Emphasis added)[32]

The Supreme Court's decision was also based on a determination that assisted suicide is not against Montana public policy.[33] The Court, however, overlooked elder abuse. *Baxter* states that the only person "who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal

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on the constitutional issues is vacated ...") Leaphart was joined by Justices Patricia O. Cotter, John Warner and Brian Morris. Warner's concurrence, ¶ 54, states "This Court correctly avoided the constitutional issue . . ." The dissent by Justice Jim Rice, joined by Joe L. Hegel, would have gone farther to state that there is no constitutional right to assisted suicide under the Montana State Constitution. See ¶¶ 111-116.

[30] *Baxter*, 354 Mont. at 251, ¶ 50, states: "We . . . hold that under § 45-2-211, MCA, "a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply."

[31] The Court stated: "[T]he comments analyze language, such as 'agent of death,' that does not even appear in the aid or soliciting statute or anywhere else in the Montana code." *Baxter*, 354 Mont. at 249, ¶ 42.

[32] Attached at A-22.

[33] *Baxter*, 354 Mont. at 250, ¶ 49.

dose of medication."[34] *Baxter* thereby overlooked criminal behavior by family members and others who benefit from a patient's death, for example, due to an inheritance. The Court thereby overlooked Montana's explicit public policy to prevent elder abuse.[35]

IV. HOW HB 505 WORKS

A. *Baxter* is Overruled

HB 505 clarifies Montana's existing prohibition against aiding or soliciting suicide in Section 45-5-105, MCA.[36] The bill has two main features: (1) it provides that physician-assisted suicide is a form of aiding or soliciting suicide; and (2) it provides that a victim's consent is not a defense.

With these two clarifications, *Baxter's* holding, that consent to assisted suicide is a defense, is overruled.

B. Doctors Receive a Clear Safe Harbor

HB 505 also gives doctors a clear safe harbor. The bill provides that the term, "physician-assisted suicide," does not include palliative care or any act to withhold or withdraw treatment. Specifically, the bill states:

> The term [physician-assisted suicide] does not include end-of-life palliative care in

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[34] *Baxter*, 354 Mont. at 239, ¶ 11.

[35] *See e.g.*, the Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act, 52-3-801, MCA; the Protective Services Act for Aged Persons or Disabled Adults, 52-3-201, MCA; and the "Montana Older Americans Act," 52-3-501, et. al., MCA.

[36] A copy of HB 505 is attached hereto at A-1 and A-2.

> which a dying person receives medication to alleviate pain that may incidentally hasten the dying person's death or any act to withhold or withdraw life-sustaining treatment authorized pursuant to Title 50, chapters 9 and 10.[37]

C. A Simplification

HB 505 also simplifies Section 45-5-105 by removing the distinction between suicides that occur and suicides that don't occur.[38]

V. HB 505 IS CONSTITUTIONAL

Assisted suicide proponents may claim that HB 505, which prohibits aiding or soliciting suicide, will be held unconstitutional under the Montana State Constitution. This is unlikely.

As described above, a proposed right to die, including a right to physician-assisted suicide, was considered and rejected in the 1972 Constitutional Convention. With this history, there is no right to physician-assisted suicide in the Montana State Constitution.

As also described above, *Baxter* vacated the district court decision holding that there is a right to physician-assisted suicide in the Montana State Constitution. Again, the vote to vacate was six justices to one. Assisted suicide proponents only got one vote. In other words, suicide proponents already brought

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[37] HB 505, attached hereto at A-1, lines 26 to 28.

[38] See HB 505, at A-1, line 14.

a constitutional challenge and lost.

With these circumstances it appears unlikely that HB 505 will be held unconstitutional.

VI. WHY HB 505 IS NEEDED

HB 505 is needed because the former Hemlock Society, Compassion & Choices, is falsely and aggressively claiming that assisted suicide is legal in Montana.[39] Compassion & Choices' website states:

> Montana is one of three states where citizens are free to choose aid in dying [assisted suicide] with no risk to the doctors or loved ones who support their choice.[40]

Compassion & Choices has also formed a "Physician Advisory Council for Aid in Dying" to facilitate the advancement of assisted suicide in Montana.[41] In addition, they have convinced the Montana Board of Medical Examiners to issue "Position Statement No. 20," to prevent doctors from being disciplined for performing assisted suicides.[42] Moreover and based on that statement, Compassion & Choices is actively recruiting doctors via direct mailings to perform assisted suicides. One of their

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[39] *See* Ian Dowbiggin, A Concise History of Euthanasia 146 (2007)("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices").

[40] Compassion & Choices's Montana Website is attached hereto at A-23.

[41] See Compassion & Choices materials attached at A-25 through A-27.

[42] See Letter from Compassion & Choices at A-24 (describing the Board's position statement). See original statement attached hereto at A-28. The current version is attached hereto at A-29. Also available at http://bsd.dli.mt.gov/license/bsd_boards/med_board/pdf/physician_aid_in_dying.pdf

mailings states:

> Physicians willing to provide [assisted suicide] can safely do so within the bounds recognized in *Baxter v. Montana* and professional practice standards.[43]

If nothing is done, there will be continuing pressure by this group in the court of public opinion. A lie or half truth repeated enough times becomes the truth. The idea of assisted suicide and/or pushing the relatives towards death will become normalized. Assisted suicides will at some point begin with no public will to prosecute. This is similar to how legalization of assisted suicide and euthanasia took hold in the Netherlands.

With a "Yes" vote on HB 505, the law will instead be clarified to overrule *Baxter* and to undermine the claim that assisted suicide is "already legal." There will be a clear tool for law enforcement and others to stop the propaganda. There will be a means to protect Montana citizens, especially the elderly.

VII. CONCLUSION

With the *Baxter* decision, assisted-suicide is not legal in Montana. *Baxter* has, however, created confusion sufficient to support arguments that assisted suicide is legal. Proponents are, regardless, actively soliciting doctors to assist suicides. If nothing is done to clarify the law, there could be defacto or

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[43] Letter from Compassion & Choices members, George Risi, MD and Stephen Speckart MD, to Dr. _____ (the name is blocked out), March 8, 2012. (Attached at A-30). See also letter from Gabor Benda, MD, attached at A-31.

actual legalization in Montana, possibly before the next legislative session.

If this occurs, Montana will experience the negative consequences of legalization, including patients throwing away their lives and new paths of elder abuse. Montana has the chance to stop it now. Vote yes on HB 505.

Respectfully submitted this 19th day of February, 2013

Bradley D. Williams, President
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Respectfully submitted this 19th day of February, 2013

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HOUSE BILL NO. 505

INTRODUCED BY K. KERNS

A BILL FOR AN ACT ENTITLED: "AN ACT CLARIFYING THE OFFENSE OF AIDING OR SOLICITING SUICIDE; CLARIFYING THAT PHYSICIAN-ASSISTED SUICIDE IS A FORM OF AIDING OR SOLICITING SUICIDE; CLARIFYING THAT THE CONSENT OF A VICTIM IS NOT A DEFENSE TO AIDING OR SOLICITING SUICIDE; PROVIDING DEFINITIONS; AMENDING SECTION 45-5-105, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 45-5-105, MCA, is amended to read:

"45-5-105. Aiding or soliciting suicide. (1) A person who purposely aids or solicits another person to commit suicide, ~~but such suicide does not occur,~~ including physician-assisted suicide, commits the offense of aiding or soliciting suicide.

(2) The consent of a victim is not a defense to the provisions of this section, and 45-2-211 does not apply.

~~(2)~~(3) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed $50,000, or both.

(4) For purposes of this section, the following definitions apply:

(a) "Aid" means to facilitate, assist, or help.

(b) (i) "Physician-assisted suicide", also known as physician aid-in-dying, means any act by a physician of purposely aiding or soliciting another person to end the person's life, including prescribing a drug, compound, or substance, providing a medical procedure, or directly or indirectly participating in an act with the purpose of aiding or soliciting suicide.

(ii) The term does not include end-of-life palliative care in which a dying person receives medication to alleviate pain that may incidentally hasten the dying person's death or any act to withhold or withdraw life-sustaining treatment authorized pursuant to Title 50, chapters 9 and 10.

(c) "Solicit" has the meaning provided in 45-2-101."

NEW SECTION. **Section 2. Effective date.** [This act] is effective on passage and approval.

NEW SECTION. **Section 3. Applicability.** [This act] applies to offenses committed on or after [the effective date of this act].

- END -

Terminal Uncertainty

Washington's new "Death With Dignity" law allows doctors to help people commit suicide—once they've determined that the patient has only six months to live. But what if they're wrong?

By Nina Shapiro
published: January 14, 2009

Nina Shapiro

Maryanne Clayton with her son, Eric, in the Fred Hutch waiting room: "I just kept going."

Details:

— Study: Why Now? Timing and Circumstances of Hastened Deaths

— Dilemmas by caretakers and other Oregon studies

— Stats on people who have used Oregon's Death with Dignity law.

— Harvard professor Nicholas Christakis looking at the accuracy of prognosis.

— JAMA study examining the accuracy of prognosis.

UPDATE: "It Felt Like the Big One"

She noticed the back pain first. Driving to the grocery store, Maryanne Clayton would have to pull over to the side of the road in tears. Then 62, a retired computer technician, she went to see a doctor in the Tri-Cities, where she lived. The diagnosis was grim. She already had Stage IV lung cancer, the most advanced form there is. Her tumor had metastasized up her spine. The doctor gave Clayton two to four months to live.

That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually built her strength. Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.

Her response was remarkable. The tumors shrunk, and although they eventually grew back, they shrunk again when she enrolled in a second clinical trial. (Pemetrexate has since been approved by the FDA for initial treatment in lung cancer cases.) She now comes to the Hutch every three weeks to see Martins, get CT scans, and undergo her drug regimen. The prognosis she was given has proved to be "quite wrong."

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip

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to Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

"We almost lost her because she was having too much fun, not from cancer," Martins chuckles.

Her experience underscores the difficulty doctors have in forecasting how long patients have to live—a difficulty that is about to become even more pertinent as the Washington Death With Dignity Act takes effect March 4. The law, passed by initiative last November and modeled closely on a 14-year-old law in Oregon, makes Washington the only other state in the country to allow terminally ill patients to obtain lethal medication. As in Oregon, the law is tightly linked to a prognosis: Two doctors must say a patient has six months or less to live before such medication can be prescribed.

The law has deeply divided doctors, with some loath to help patients end their lives and others asserting it's the most humane thing to do. But there's one thing many on both sides can agree on. Dr. Stuart Farber, head of palliative care at the University of Washington Medical Center, puts it this way: "Our ability to predict what will happen to you in the next six months sucks."

In one sense, six months is an arbitrary figure. "Why not four months? Why not eight months?" asks Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, adding that medical literature does not define the term "terminally ill." The federal Medicare program, however, has determined that it will pay for hospice care for patients with a prognosis of six months or less. "That's why we chose six months," explains George Eighmey, executive director of Compassion & Choices of Oregon, the group that led the advocacy for the nation's first physician-assisted suicide law. He points out that doctors are already used to making that determination.

To do so, doctors fill out a detailed checklist derived from Medicare guidelines that are intended to ensure that patients truly are at death's door, and that the federal government won't be shelling out for hospice care indefinitely. The checklist covers a patient's ability to speak, walk, and smile, in addition to technical criteria specific to a person's medical condition, such as distant metastases in the case of cancer or a "CD4 count" of less than 25 cells in the case of AIDS.

No such detailed checklist is likely to be required for patients looking to end their lives in Washington, however. The state Department of Health, currently drafting regulations to comply with the new law, has released a preliminary version of the form that will go to doctors. Virtually identical to the one used in Oregon, it simply asks doctors to check a box indicating they have determined that "the patient has six months or less to live" without any additional questions about how that determination was made.

Even when applying the rigid criteria for hospice eligibility, doctors often get it wrong, according to Nicholas Christakis, a professor of medicine and sociology at Harvard University and a pioneer in research on this subject. As a child, his mother was diagnosed with Hodgkin's disease. "When I was six, she was given a 10 percent chance of living beyond three weeks," he writes in his 2000 book, *Death Foretold: Prophecy and Prognosis in Medical Care*. "She lived for nineteen remarkable years...I spent my boyhood always fearing that her lifelong chemotherapy would stop working, constantly wondering whether my mother would live or die, and both craving and detesting prognostic precision."

Sadly, Christakis' research has shown that his mother was an exception. In 2000, Christakis published a study in the *British Medical Journal* that followed 500 patients admitted to hospice programs in Chicago. He found that only 20 percent of the patients died approximately when their doctors had predicted. Unfortunately, most died *sooner*. "By and large, the physicians were overly optimistic," says Christakis.

In the world of hospice care, this finding is disturbing because it indicates that many patients aren't being referred early enough to take full advantage of services that might ease their final months. "That's what has frustrated hospices for decades," says Wayne McCormick, medical director of Providence Hospice of Seattle, explaining that hospice staff frequently don't get enough time with patients to do their best work.

Death With Dignity advocates, however, point to this finding to allay concerns that people might be killing themselves too soon based on an erroneous six-month prognosis. "Of course, there is the occasional person who outlives his or her prognosis," says Robb Miller, executive director of Compassion & Choices of Washington. Actually, 17 percent of patients did so in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses.

It's not that prognostication is completely lacking in a scientific basis. There is a reason that you can pick up a textbook and find a life expectancy associated with most medical conditions: Studies have followed *populations* of people with these conditions. It's a statistical average. To be precise, it's a median, explains Martins. "That means 50 percent will do worse and 50 percent will do better."

Doctors also shade their prognoses according to their own biases and desires. Christakis' study found that the longer a doctor knew a patient, the more likely their prognosis was inaccurate, suggesting that doctors who get attached to their patients are reluctant to talk of their imminent demise. What's more, Christakis says, doctors see death "as a mark of failure."

Oncologists in particular tend to adopt a cheerleading attitude "right up to the end," says Brian Wicks, an orthopedic surgeon and past president of the Washington State Medical Association. Rather than talk about death, he says, their attitude is "Hey, one more round of chemo!"

But it is also true that one more round of chemo, or new drugs like the one that helped Clayton, or sometimes even just leaving patients alone, can help them in ways that are impossible to predict. J. Randall Curtis, a pulmonary disease specialist and director of an end-of-life research program at Harborview Medical Center, recalls treating an older man with severe emphysema a couple of years ago. "I didn't think I could get him off life support," Curtis says. The man was on a ventilator. Every day Randall tested whether the patient could breathe on his own, and every day the patient failed the test. He had previously made it clear that he did not want to be kept alive by machines, according to Curtis, and so the doctor and the man's family made the wrenching decision to pull the plug.

But instead of dying as expected, the man slowly began to get better. Curtis doesn't know exactly why, but guesses that for that patient, "being off the ventilator was probably better than being on it. He was more comfortable, less stressed." Curtis says the man lived for at least a year afterwards.

Curtis also once kept a patient on life support against his better judgment because her family insisted. "I thought she would live days to weeks," he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come back for a visit some six or eight months later.

"It was humbling," he says. "It was not amazing. That's the kind of thing in medicine that happens frequently."

Every morning when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.

"There's always a little triumph," Bud chimes in. "I made it for another day."

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

Then 75, "he became old almost overnight," Heidi says. Still, Bud was put on medications that kept him going—long enough to have a stroke five years later, kidney failure the year after that, and then the onset of severe chest pain known as angina. "It was scary," says Heidi, who found herself struggling at 3 a.m. to find Bud's veins so she could inject the morphine that the doctor had given Bud for the pain. Heidi is a petite blond nurse with a raucous laugh. She's 20 years younger than her husband, whom she met at a military hospital, and shares his cigar-smoking habit. Bud was a high-flying psychiatrist in the '80s when he became the U.S. Assistant Secretary of Defense, responsible for all Armed Forces health activities.

After his onslaught of illnesses, Bud says, his own prognosis for himself was grim. "Looking at a patient who had what I had, I would have been absolutely convinced that my chance of surviving more than a few months was very slim indeed."

Bud's doctor eventually agreed, referring him to hospice with a prognosis of six months. That was a year and a half ago. Bud, who receives visits from hospice staff at home, has since not gotten much worse or much better. Although he has trouble walking and freely speaks of himself as "dying," he looks like any elderly grandfather, sitting in a living room decorated with mounted animal heads, stuffing tobacco into his pipe and chatting about his renewed love of nature and the letter he plans to write to Barack Obama with his ideas for improving medical care. Despite his ill health, he says the past few years have been a wonderful, peaceful period for him—one that physician-assisted suicide, which he opposes, would have cut short.

A year after he first began getting visits from the Franciscan Hospice, the organization sent Dr. Bruce Brazina to Mayer's home to certify that he was still really dying. It's something Brazina says he does two to four times a week as patients outlive their six-month prognoses. Sometimes, Brazina says, patients have improved so much he can no longer forecast their imminent death. In those cases, "we take them off service"—a polite way of saying that patients are kicked off hospice care, a standard procedure at all hospices due to Medicare rules. But Brazina found that Mayer's heart condition was still severe enough to warrant another six-month prognosis, which the retired doctor has just about outlived again.

"It's getting to the point where I'm a little embarrassed," Mayer says.

What's going on with him is a little different than what happened to Randall Curtis' patients or to Maryanne Clayton. Rather than reviving from near death or surviving a disease that normally kills quickly, Mayer is suffering from chronic diseases that typically follow an unpredictable course. "People can be very sick but go along fine and stable," Brazina explains. "But then they'll have an acute attack." The problem for prognosis is that doctors have no way of knowing when those attacks will be or whether patients will be able to survive them.

When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*.

Given these two studies, it's no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there's no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there's no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn't track whether they ever received the medication and a six-month prognosis).

The medical field's spotty track record with prognosis is one reason Harborview's Curtis says he is not comfortable participating in physician-assisted suicide. It's one thing to make a six-month prognosis that will allow patients access to hospice services, he says, and quite another to do so for the purpose of enabling patients to kill themselves. "The consequences of being wrong are pretty different," he says.

Under the law, doctors and institutions are free to opt out, and several Catholic institutions like Providence Hospice of Seattle have already said they will do so. Medical director McCormick finds the idea of patients killing themselves particularly troubling because "you can't predict what's going to happen or who's going to show up near the end of your life." He says he has watched people make peace with loved ones or form wonderful new connections. He's preparing a speech in case patients ask about the new law: "I will stop at nothing to ensure that you're comfortable. I won't shorten your life, but I will make it as high-quality as possible."

Thomas Preston, a retired cardiologist who serves as medical director of Compassion & Choices of Washington, says he has in mind a different kind of speech: "You have to understand that this prognosis could be wrong. You may have more than six months to live. You may be cutting off some useful life."

He also says he will advise doctors to be more conservative than the law allows. "If you think it's going to be six months, hold off on it [writing a prescription]—just to be sure." Instead, he'll suggest that doctors wait until they think a patient has only one or two months to live.

The UW's Farber leans toward a different approach. While he says he hasn't yet decided whether he himself will write fatal prescriptions, he plans at least to refer patients to others who will. Given that prognostic precision is impossible, he says, "I personally just let go of the six months." Instead, he says he would try to meet what he sees as the "spirit of the law" by assessing that someone is "near" the end of their life, so that he could say to them, "You're really sick and you're not going to get better."

Knowing exactly when someone is going to die, he continues, is not as important as knowing when someone "has reached the point where their life is filled with so much suffering that they don't want to be alive."

Randy Niedzielski reached that point in the summer of 2006, according to his wife Nancy. Diagnosed with brain cancer in 2000, the onetime Lynnwood property manager had been through several rounds of chemotherapy and had lived years longer than the norm. But the cancer cells had come back in an even more virulent form and had spread to his muscle system. "He would have these bizarre muscle contractions," Nancy recalls. "His feet would go into a cone shape. His arms would twist in weird angles." Or his chest would of its own volition go into what Nancy calls a "tent position," rising up from his arms. "He'd just be screaming in pain."

Randy would have liked to move to Oregon to take advantage of the Death With Dignity Act there, according to Nancy. But he didn't have time to establish residency as required. That was about six weeks before his death.

Nancy, who has become an advocate for physician-assisted suicide, says that typically people are only weeks or days away from death when they want to kill themselves. Oregon's experience with people hanging onto their medicine for so long, rather than rushing to use it as soon as they get a six-month prognosis, bears this out, she says: "A patient will know when he's at the very end of his life. Doctors don't need to tell you."

Sometimes, though, patients are not so near the end of their life when they're ready to die. University of Washington bioethics professor Helene Starks and Anthony Back, director of palliative care at the Seattle Cancer Care Alliance, are two of several researchers who in 2005 published a study that looked at 26 patients who "hastened" their death. A few were in Oregon, but most were in Washington, and they brought about their own demise mostly either by refusing to eat or drink or by obtaining medication illegally, according to Back and Starks. Three of these patients had "well over six months" of remaining life, Starks says, perhaps even years.

The paper, published in the *Journal of Pain and Symptom Management*, quotes from an interview with one of these patients before she took her life. Suffering from a congenital malformation of the spine, she said it had reached the point that her spine or neck could be injured even while sitting. "I'm in an invisible prison," she continued. "Every move I make is an effort. I can't live like this because of the constant stress, unbearable pain, and the knowledge that it will never be any better."

Under the law, she would not be eligible for lethal medication. Her case was not considered "terminal," according to the paper. But for patients like her, the present is still unbearable. Former governor Booth Gardner, the state's most visible champion of physician-assisted suicide, would have preferred a law that applied to everyone who viewed their suffering this way, regardless of how long they were expected to live. He told *The New York Times Magazine*, for a December 2007 story, that the six-month rule was a compromise meant to help insure the passage of Initiative 1000. Gardner has Parkinson's disease, and now can talk only haltingly by phone. In an interview he explained that he has been housebound of late due to several accidents related to his lack of balance.

Researchers who have interviewed patients, their families, and their doctors have found, however, that pain is not the central issue. Fear of future suffering looms larger, as does people's desire to control their own end.

"It comes down to more existential issues," says Back. For his study of Washington and Oregon patients, he interviewed one woman who had been a successful business owner. "That's what gave her her zest for life," Back says, and without it she was ready to die.

Maryanne Clayton says she has never reached that point. Still, she voted for the Death With Dignity Act. "Why force me to suffer?" she asks, adding that if she were today in as much pain as she was when first diagnosed with lung cancer, she might consider taking advantage of the new law. But for now, she still enjoys life. Her 35-year-old son Eric shares a duplex with her in the Tri-Cities. They like different food. But every night he cooks dinner on his side, she cooks dinner on her side, and they eat together. And one more day passes that proves her prognosis wrong.

nshapiro@seattleweekly.com

CANADA **C O U R S U P É R I E U R E**

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF JEANETTE HALL
OPPOSING ASSISTED SUICIDE

THE UNDERSIGNED, being first duly sworn under oath, states:

1. I live in Oregon where physician-assisted suicide is legal. Our law was enacted in 1997 via a ballot initiative that I voted for.

2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I tried to ask my doctor, Ken Stevens MD, but he didn't really answer me. In hindsight, he was stalling me.

3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

4. This July, it was 12 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 17th day of August 2012

Jeanette Hall

Jeanette Hall

SWORN BEFORE ME at
OREGON, USA
on, August 17, 2012

NAME: Sheena Leslie

A notary in and for the
State of Oregon

ADDRESS: 15905 SW 116th Ave
Tigard, OR 97224

EXPIRY OF COMMISSION:
September 28, 2015

PLACE SEAL HERE:

JEANETTE HALL

OFFICIAL SEAL
SHEENA MARIE LESLIE
NOTARY PUBLIC - OREGON
COMMISSION NO. 462203
MY COMMISSION EXPIRES SEPTEMBER 28, 2015

CANADA **C O U R S U P É R I E U R E**

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have treated thousands of patients with cancer.

2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify for the court that this does not necessarily mean that patients are dying.

3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer. I understand that he had referred her to me.

4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, *i.e.*, kill herself with a lethal dose of barbiturates. It was very much a settled decision.

5. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.

6. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive. It's been twelve years.

7. For Jeanette, the mere presence of legal assisted suicide had steered her to suicide.

8. Today, for patients under the Oregon Health Plan (Medicaid), there is also a financial incentive to commit suicide: The Plan covers the cost. The Plan's "Statements of Intent for the April 1, 2012 Prioritized List of Health Services," states:

> It is the intent of the [Oregon Health Services] Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services.

Attached hereto at page SI-1.

9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. For example, patients with cancer are denied treatment if they have a "less than 24 months median survival with treatment" and fit other criteria. This is the Plan's "Guideline Note 12." (Attached hereto at page GN-4).

10. The term, "less than 24 months median survival with treatment," means that statistically half the patients receiving treatment will live less than 24 months (two years) and the other half will live longer than two years.

11. Some of the patients living longer than two years will likely live far longer than two years, as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

12. All such persons who fit within "Guideline Note 12" will nonetheless be denied treatment. Their suicides under Oregon's assisted suicide act will be covered.

13. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.

SWORN BEFORE ME at Sherwood
Oregon, USA
on, September 18, 2012

NAME: Jessica Borgo

A notary in and for the
State of Oregon

ADDRESS: 16100 SW Tualatin-Sherwood Rd

EXPIRY OF COMMISSION: Aug, 30, 2015

PLACE SEAL HERE: Jessica Borgo

Ken Stevens MD
Ken Stevens, MD

OFFICIAL SEAL
JESSICA R BORGO
NOTARY PUBLIC - OREGON
COMMISSION NO. 461438
MY COMMISSION EXPIRES AUGUST 30, 2015

STATEMENT OF INTENT 1: PALLIATIVE CARE

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the goals for medical treatment and with services available according to the patient's expected length of life (see examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening/limiting illness,

A) without regard to a patient's expected length of life:
   - Inpatient palliative care consultation; and,
   - Outpatient palliative care consultation, office visits.

B) with an expected median survival of less than one year, as supported by the best available published evidence:
   - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.

C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
   - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

It is the intent of the Commission that certain palliative care treatments be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

A) Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
B) Surgical decompression for malignant bowel obstruction.
C) Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
D) Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.
E) Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Guideline Note 12: TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE.

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.

GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through
2) Radiological evidence of lack of stricture
3) Only covered once during any episode of illness
4) FDA approved devices must be used
5) Patency capsule should not be used prior to procedure

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (363.21) should only be treated in patients with 20/40 or worse vision..

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

Lines 79,102,103,105,123-125,131,144,159,165,166,168,170,181,197,198,206-208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,314,320,339-341,356,459,622

A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapy regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.
B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.
C) CSF are not indicated in patients who are acutely neutropenic but afebrile.
D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <100/mcl, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.
E) CSF are not indicated to increase chemotherapy dose-intensity or schedule, except in cases where improved outcome from such increased intensity has been documented in a clinical trial.
F) CSF (other than pegfilgrastrim) are indicated in the setting of autologous progenitor cell transplantation, to mobilize peripheral blood progenitor cells, and after their infusion.
G) CSF are NOT indicated in patients receiving concomitant chemotherapy and radiation therapy.
H) There is no evidence of clinical benefit in the routine, continuous use of CSF in myelodysplastic syndromes. CSF may be indicated for some patients with severe neutropenia and recurrent infections, but should be used only if significant response is documented.
I) CSF is indicated for treatment of cyclic, congenital and idiopathic neutropenia.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE

Lines 102,103,123-125,144,159,165,166,170,181,197,198,207,208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,320,339-341,356,459,586,622

This guideline only applies to patients with advanced cancer who have less than 24 months median survival with treatment.

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:
- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

Unpublished evidence may be taken into consideration in the case of rare cancers which are universally fatal within six months without treatment.

The Health Evidence Review Commission is reluctant to place a strict $/QALY (quality adjusted life-year) or $/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend $100,000 in public resources to increase an individual's expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE (CONT'D)

Treatment with the goal to palliate is addressed in Statement of Intent 1, Palliative Care.

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

Minimally invasive coronary artery bypass surgery indicated only for single vessel disease.

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79,103,105,125,131,166,170,198,206,231,280,314

Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

Radiation treatment is indicated only in those at high risk of heterotopic bone formation: those with a history of prior heterotopic bone formation, ankylosing spondylitis or hypertrophic osteoarthritis.

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

Cystic fibrosis carrier testing is covered for 1) non-pregnant adults if indicated in the genetic testing algorithm or 2) pregnant women.

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

Dental cleaning and fluoride treatments are limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120, D1203, D1204, D1206). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

A) as a bridge to cardiac transplant;
B) as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant; or,
C) as a bridge to recovery.

Ventricular assist devices are not covered for destination therapy.

Ventricular assist devices are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.

GUIDELINE NOTE 19, PET SCAN GUIDELINES

Lines 125,144,165,166,170,182,207,208,220,221,243,276,278,292,312,339

PET Scans are covered for diagnosis of the following cancers only:

- Solitary pulmonary nodules and non-small cell lung cancer
- Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:

- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal

A RECIPE FOR ELDER ABUSE

Julie's Sign: No assisted suicide. No assisted elder abuse. Preserve choice for seniors.

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VOICES FROM OREGON AND WASHINGTON WHERE ASSISTED SUICIDE IS LEGAL

- "I was afraid to leave my husband alone"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "In Oregon, the only help my patient received was a lethal prescription, intended to kill him."
- "It wasn't the father saying that he wanted to die"
- "He simply said 'Thank you.'"
- "He made the

Montana Constitution Does Not Include a "Right to Die"

By Margaret Dore
Updated January 20, 2013

In 1972, Montana held its Constitutional Convention. At that time, the Bill of Rights Committee was charged with drafting a declaration of rights for the new constitution.

On February 2, 1972, the Committee received "Delegate Proposal 103," which proposed "the right to be born and the right to be die."[1]

On February 3, 1972, the Committee held a hearing on the "right to die."[2] According to the Committee Minutes, "Mrs. Joyce Franks presented the theory to the Committee that all persons should be able to choose his own death with dignity."[3] The record also includes her seven page written submission, titled "Bill of Rights Speech."[4] In this document, she proposed wording for a constitutional right to die; she discussed her father's long and painful death, and the right to die in terms of physician-assisted suicide and/or euthanasia.[5]

Other persons also submitted testimony, for and against.[6]

On February 9, 1972, the Bill of Rights Committee rejected Proposal #103, the "Right to Die."[7]

WELCOME!

Legal physician-assisted suicide encourages people with years to live to throw away their lives.

Legal physician-assisted suicide is a recipe for elder abuse.

In Oregon, legalization allows the Oregon Health Plan to steer citizens to suicide.

In Oregon, other suicides have increased with legalization.

For more information, see Quick Facts About Assisted Suicide.

JOIN BRADLEY WILLIAMS IN THE FIGHT AGAINST ASSISTED SUICIDE

Click on photo to watch Bradley

mistake of asking for information about assisted suicide"
- "Dr. Stevens, you saved my life!"

CHOICE IS AN ILLUSION

Click on the banner to learn about the fight against assisted suicide in other stat

MAJOR TOPICS

- Updated Quick Facts About Assisted Suicide
- MAAS Files New Lawsuit Against Board
- Physician-assisted suicide is not legal in Montana.
- Legal analysis of failed bill to legalize assisted suicide, SB 167
- Baxter case analysis

BLOG ARCHIVE

▼ 2013 (20)
- ► February (9)
- ▼ January (11)
  - Physician-assisted suicide runs risk of invisible ...
  - Assisted suicide would exacerbate problem of elder...
  - Oregon doctor could not save patient from assisted...
  - Oregon Assisted Suicide Law is Not Safe According ...
  - "Dr. Stevens, you saved my life!"
  - Oregon Doctor's Letter to Medical Society
  - "I was afraid to leave my

On February 12, 1972, Joe Roberts appeared before the Committee in support of the right to die.[8] He noted the reason for the Committee's rejection of the right to die, as follows:

"[T]he consensus of the delegates I have talked to indicated that while they were sympathetic to Mrs. Frank's personal tragedy, they were afraid of the implications of stating broadly a Right to Die in the Montana Constitution.[9]

On March 18, 1972, the Committee's "Declaration of Rights" was adopted by the full convention without the right to die.[10]

Today, the Committee's Declaration of Rights is Article II of the Montana Constitution.[11]

With this history, there is no right to die in the Montana Constitution: it was proposed; advocated by Mrs. Franks and other persons; and rejected.

* * *

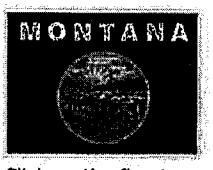
[1] Delegate Proposal 103 can be viewed at http://maasdocuments.files.wordpress.com/2012/09/archived-del-proposal-103-rtd.pdf
[2] See Committee Minutes for February 3, 1972 (listing the "Subject of Hearing" as "18 year old vote, proposal #13 [and] Right to Die"), available at http://maasdocuments.files.wordpress.com/2012/09/archived-rtd-test-feb-3-hearing-7_0011.pdf
[3] Minutes, page 2 (middle of the page), available at http://maasdocuments.files.wordpress.com/2012/09/archived-rtd-test-feb-3-hearing-7_0011.pdf
[4] Mrs. Franks' testimony form and seven page document are available at http://maasdocuments.files.wordpress.com/2012/10/archived-mrs-franks-materials-02-03-721.pdf
[5] In Mrs. Franks' materials, it's not clear whether she is talking about "physician-assisted suicide" in which the patient commits the life ending act, or "euthanasia" in which the patient's death is directly caused by another person. See her materials at http://maasdocuments.files.wordpress.com/2012/10/archived-mrs-franks-materials-02-03-721.pdf
[6] Kenneth Henry wrote: "Euthanasia. I wish to support the idea." Stella Fila____ opposed "abortion on demand" and "euthanasia." See this link: http://maasdocuments.files.wordpress.com/2012/09/archived-documents-put-in-record-2-3-72.pdf
[7] See Committee Minutes for February 9, 1972, pp.

Williams speak against assisted suicide

PRINT OUR HANDOUTS!

- Quick Facts About Assisted Suicide
- "Aid in Dying" Whose Choice?
- Talking Points
- US Overview (Idaho article)
- Terminal Uncertainty
- Laws Against Assisted Suicide are Constitutional
- Not Legal in MT
- What People Mean When They Say They Want to Die
- Bullet Points Handout

STOP ASSISTED SUICIDE



Click on the flag to learn how you can help stop assisted suicide in Montana

LABELS

- aid in dying (48)
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1 & 2 ("The following decisions were made: . . . #103-Out . . ."), available at http://maasdocuments.files.wordpress.com/2012/09/archived-rtd-103-rejected-2-9-72.pdf

[8] See Mr. Roberts' testimony form at this link: http://maasdocuments.files.wordpress.com/2012/09/archived-joe-roberts-test-in-minutes-for-4-12-72.pdf

[9] The above quote is from the first paragraph of Mr. Roberts' written remarks, which can be viewed on the page after the testimony form at this link: http://maasdocuments.files.wordpress.com/2012/09/archived-joe-roberts-test-in-minutes-for-4-12-72.pdf

[10] To see the text of the Declaration of Rights submitted to the full Convention, along with a preamble, go here: http://maasdocuments.files.wordpress.com/2012/09/archived-bill-rts-final-3-18-72_001.pdf To see the Convention's roll vote, go here: http://maasdocuments.files.wordpress.com/2012/09/archived-conv-vote-3-18-72.pdf

[11] The entire Montana Constitution can be viewed here: http://courts.mt.gov/content/library/docs/72constit.pdf

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the safety or rights of others, the instructions taken as a whole are correct. For while the former may, standing alone, be inaccurate or even erroneous, yet as qualified and explained by other portions of the charge, in pari materia, it fully and fairly submitted the case to the jury. St. v Bosch, 125 M 566, 242 P2d 477 (1952).

Evidence in a manslaughter prosecution showing that defendant driver, blinded by bright lights of an approaching car, drove off the highway into a shallow depression filled with a pile o rocks hidden by brush, causing the car to sideswipe a tree, was insufficient to sustain conviction on theory of criminal negligence. St. v. Bast, 116 M 329, 151 P2d 1009 (1944).

Conviction of involuntary manslaughter in the commission of a lawful act required a higher degree of negligence than to establish liability in a civil case; it required aggravated, culpable, o gross negligence or recklessness, a disregard for human life, or an indifference to consequences such a departure from the conduct of an ordinarily prudent or careful man under th circumstances as to be incompatible with a proper regard for human life. St. v. Powell, 114 M 571, 138 P2d 949 (1943).

The negligent handling of a loaded firearm causing or contributing to the death of another person could be found to support a conviction of involuntary manslaughter. St. v. Kuum, 55 M 436, 178 P 288 (1919).

Double Jeopardy: Prosecution for involuntary manslaughter under 94-2507, R.C.M. 194 (since repealed), was not barred by defendant's prior conviction upon guilty pleas to drivin while intoxicated and operating motor vehicle with improper brakes arising from same acciden St. v. McDonald, 158 M 307, 491 P2d 711 (1971).

Failure to Provide:

Where wife died from subdural hematoma after a period of unconsciousness, husband failure to summon medical assistance for period of 28 hours was not such degree of culpab negligence as to support a conviction of involuntary manslaughter under 94-2507, R.C.M. 194 (now MCA, 45-5-104), where unconsciousness appeared to have been from intoxication, wi appeared to be breathing well, and friend advised only bed rest. St. v. Decker, 157 M 361, 48 P2d 695 (1971).

Husband's failure to provide medical attention for wife for 2 days after she fell and sustaine serious injuries was such culpable negligence as to support conviction for involuntar manslaughter, even though wife protested that she did not need attention, where she was semicomatose condition and obviously did need attention. St. v. Mally, 139 M 599, 366 P2d 8 (1961), followed in State ex rel. Kuntz v. District Court, 2000 MT 22, 298 M 146, 995 P2d 951, St. Rep. 111 (2000).

Failure of parents to provide food for baby, with resulting death from starvation, the bal weighing only 10 ounces more at 5 months than at birth, was such culpable negligence as to sho a disregard for human life or an indifference to consequences and would support a conviction f involuntary manslaughter even without an intention to cause death. St. v. Bischert, 131 M 15 308 P2d 969 (1957).

Intent:

Willful or evil intent was not an element of involuntary manslaughter under 94-2507, R.C.M 1947 (now MCA, 45-5-104). St. v. Pankow, 134 M 519, 333 P2d 1017 (1959); St. v. Messerly, 1 M 62, 244 P2d 1054 (1952); St. v. Souhrada, 122 M 377, 204 P2d 792 (1949).

In prosecution for involuntary manslaughter under 94-2507, R.C.M. 1947 (now MC 45-5-104), the issue was one of criminal negligence rather than intent, and instruction th "intent is not an element of involuntary manslaughter" was proper. St. v. Souhrada, 122 M 3 204 P2d 792 (1949).

45-5-105. Aiding or soliciting suicide.

Criminal Law Commission Comments

Source: New.

If the conduct of the offender made him the agent of the death, the offense is crimi homicide notwithstanding the consent or even the solicitations of the victim. See secti 94-5-101 through 94-5-105 [now MCA, 45-5-102 through 45-5-104].

Rather than relying on aiding or soliciting an attempted homicide, this section sets forth specific formula to make such acts punishable. The rationale behind the felony sentence for substantive offense of aiding or soliciting suicide is that the act typifies a very low regard human life.

Montana

Montana is one of three states where citizens are free to choose aid in dying with no risk to the doctors or loved ones who support their choice.

The Montana Supreme Court held in December 2009 that the Montana State Constitution protects a peaceful death with dignity, making Montana the third state to provide its residents with legal aid in dying in the successful Baxter et al v. Montana case.

Despite the landmark Baxter decision and subsequent Board of Medical Examiners' policy backing this freedom, opponents threaten to undermine the right every legislative session. Compassion & Choices' on-the-ground advocates have fended them off for two years, and during this session we need your help.

compassion & choices
Montana
Support. Educate. Advocate. Choice & Care at the End of Life.

June 5, 2012

Dear Montana Physician,

Montanans are independent. Montanans are thoughtful. They believe in privacy. That's why the Montana constitution is written to guarantee personal privacy and dignity. Terminally ill Montanans are guaranteed the right to choice, privacy and dignity at the end of life. On December 31, 2009, the Montana Supreme Court ruled terminally ill Montanans have the right to choose aid in dying under state law. The court's decision set clear boundaries for this intervention: the patient must be terminally ill and mentally competent, and the physician may provide, but not administer, a prescription for life-ending medication. Only the patient may administer this medication. Physicians can provide prescriptions to such patients without fear that doing so could give rise to criminal or disciplinary sanction.

Compassion & Choices Montana has been working tirelessly with medical professionals and citizen activists to educate the public, implement the practice with appropriate safeguards and protect the right of Montanans to die with dignity. Recently, the Montana Board of Medical Examiners (BME) adopted a new policy further establishing aid in dying as a medical intervention to be governed, as with all other medical interventions, by professional practice standards. Specifically the BME Policy states:

> *"The Montana Board of Medical Examiners has been asked if it will discipline physicians for participating in aid-in-dying. This statement reflects the Board's position on this controversial question.*
>
> *The Board recognizes that its mission is to protect the citizens of Montana against the unprofessional, improper, unauthorized and unqualified practice of medicine by ensuring that its licensees are competent professionals. 37-3-101, MCA. In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct as defined by the laws and rules pertinent to the Board."*
>
> *(http://bsd.dli.mt.gov/license/bsd_boards/med_board/board_page.asp)*

Physician Advisory Council for Aid in Dying

Compassion & Choices Montana's End-of-Life Consultation service is actively helping patients; families and medical practitioners understand aid in dying and navigate the emotional and clinical landscape of terminal illness. We are currently in the process of forming the Montana Physician Advisory Council for Aid in Dying (PACAID) with the primary goal of helping physicians empower terminally ill patients in Montana with the ability to control their suffering and choose their manner of death. To accomplish this goal, members of PACAID will:

1. Adopt best-practice guidelines for aid-in-dying practice in Montana.
2. Serve as a prescribing physician.
3. Advise physicians, hospices and requesting patients.
4. Shepherd affirmative policy through local medical organizations.

We need your help. Please consider joining the Montana Physician Advisory Council for Aid in Dying. To learn more, ask questions or get involved, please call Patrick Johnson at 406-552-2916 or email at Plohnson@compassionandchoices.org.

Sincerely,

Judy Neall Epstein, N.D.

Judy Neall Epstein, ND
Clinical Director
End-of- Life Consultation Program
Compassion & Choices

Eric Kress

Eric Kress, MD
Chair
Montana Physician Advisory Council for
Aid in Dying

Enclosure: PACAID Recruitment Flyer

Physician Advisory Council for Aid in Dying

Helping physicians empower terminally ill patients in Montana with the ability to control their suffering and choose their manner of death.

End-of-Life Care in Montana

The State of Montana authorizes a range of end-of-life care options, including but not limited to:

- Discontinuing life-prolonging modalities such as dialysis, pacemakers, antibiotics, or other medication;
- Providing palliative support to a patient who elects to stop eating and drinking;
- Administering palliative sedation upon the request of the patient;
- Providing medication to provide peace of mind that peaceful dying is achievable.

The medical practice of aid in dying for terminally ill patients is becoming more established, as evidenced by the increasing number of states where aid in dying is openly available and by the growing number of professional medical organizations that support open access to aid in dying: the American College of Legal Medicine (ACLM), the American Medical Women's Association (AMWA), the American Medical Student Association (AMSA); the American Academy of Hospice and Palliative Medicine (AAHPM) has shifted its stand from oppositional to neutral.

Montana Physicians Are Authorized to Provide Aid in Dying Subject to Professional Best-Practice Standards

The *Baxter* decision, handed down by the Montana Supreme Court on December 31, 2009, affirmed that aid in dying is legal in Montana. The Court's decision specified that a patient must: (1) have a terminal illness; (2) be within six months of death; and (3) be of sound mind.

In response to the Baxter decision, the Board of Medical Examiners (BOME) issued a formal statement on January 20, 2012 clarifying the Board will treat aid in dying as it would any other medical procedure or intervention when evaluating physician conduct. The BOME statement entrusts physicians in Montana to set the standard of care for aid in dying as they have with other end-of-life practices.

Physician Advisory Council for Aid in Dying

The primary goal of the Montana Physician Advisory Council for Aid in Dying (PACAID) is to help physicians empower terminally ill patients to control their suffering and choose the manner and timing of death. To accomplish this goal, members of Montana PACAID will:

1. Adopt best-practice guidelines for aid-in-dying medical practice in Montana. Montana law entrusts physicians to set the standard of care for aid in dying as they have with other end-of-life practices. Physicians have established standards of practice in Oregon and Washington. Members of the Montana PACAID will help physicians adopt these standards and integrate aid in dying into end-of-life care in Montana.

2. Advise physicians, hospices and requesting patients. As the medical practice of aid in dying matures in Montana, physicians will receive increased requests. Hospices and individual hospice workers will benefit from information, guidance and emotional support from knowledgeable and supportive colleagues. All will need reassurance that what they are doing conforms to a medical best-practice standard, which shields them from criminal conviction and professional discipline.

3. Serve as a prescribing physician. Patients will need support and direction to talk with their physicians about aid in dying. Members of the PAC with current licenses and prescribing privileges for controlled substances can serve a consulting role as a prescribing physician.

4. Shepherd affirmative policies through local medical organizations. Members of PACAID will work with the Montana medical organizations to encourage adoption of affirmative policies and documented support of the medical practice of aid in dying.

5. Develop, grow and lead the Physician Coalition for Aid in Dying. The Physician Coalition for Aid in Dying will be a network of supportive physicians that will:

a. Lend their names and reputations to this effort by helping the public and medical community understand aid in dying as an available option in the palliative continuum at the end of life;

b. Inform physicians of Compassion & Choices' End-of-Life Consultation program for support and information, for their patients and themselves;

c. Educate medical providers and answer their concerns about prescribing or referring patients to prescribing physicians;

d. Serve as a prescribing physician;

e. Develop relationships with pharmacists so prescriptions can be filled locally; and

f. Provide professional education through grand rounds.

Please Join the Montana Physician Advisory Council for Aid in Dying

To learn more, please call Patrick Johnson at 406.552.2916 or email at PJohnson@compassionandchoices.org

Physician Aid In Dying

In Baxter v. State of Montana, 354 Mont. 234, 224 P.3d 1211, the Montana Supreme Court ruled that the Rights of the Terminally Ill Act, 50-9-101, MCA, et seq., and the consent defense found in 45-2-211, MCA shield a physician from liability for acting in accordance with a patient's end-of-life wishes if an adult, mentally competent terminally ill patient consents to the physician's aid-in-dying. As a result of this decision, the Montana Board of Medical Examiners has been asked if it will discipline physicians for participating in such aid-in-dying. This statement reflects the Board's position on this controversial question.

The Board recognizes that its mission is to protect the citizens of Montana against the unprofessional, improper, unauthorized and unqualified practice of medicine by ensuring that its licensees are competent professionals. 37-3-101, MCA. In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct as defined by the laws and rules pertinent to the Board."

implies that physician "aid in dying" (assisted suicide) is a "medical procedure or intervention.

This is the original "Position Statement No. 20" adopted on Jan 10, 2012.

Montana Department of
LABOR & INDUSTRY
Business Standards Division
Montana Board of Medical Examiners

Physician Aid in Dying
(as of March 16, 2012)

The Montana Board of Medical Examiners has been asked if it will discipline physicians for participating in aid-in-dying. This statement reflects the Board's position on this controversial question.

The Board recognizes that its mission is to protect the citizens of Montana against the unprofessional, improper, unauthorized and unqualified practice of medicine by ensuring that its licensees are competent professionals. 37-3-101, MCA. In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct as defined by the laws and rules pertinent to the Board."

Adopted January 20, 2012
Revised March 16, 2012

refers to "physician aid-in-dying" (physician-assisted suicide) as a "medical procedure or intervention."

This statement was enacted as "Position Statement No. 20."

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TTD (406) 444-0532
"AN EQUAL OPPORTUNITY EMPLOYER"

George Risi, M.D. • Stephen Speckart, M.D.
P.O. Box 1348 • Helena, MT 59624

March 8, 2012

Compassion & Choices mailbox.

Dr.

RE: BME Position on Aid in Dying

Dear Dr.

As you may be aware, in 2009 the Montana Supreme Court ruled that no basis exists to prosecute a physician for providing aid in dying. Aid in dying refers to the medical practice of a physician providing a prescription to a mentally competent, terminally ill adult patient for medication that the patient may choose to ingest to achieve a peaceful death if they find their suffering unbearable. We were involved in that case, known as *Baxter v. Montana*[1].

The court's decision did not address the question of whether a physician providing aid in dying had reason to fear disciplinary action. We are writing to share with you the important news that the Board of Medical Examiners recently adopted a position statement on aid in dying, advising:

> *"In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct..."*[2]

Physicians willing to provide this option can safely do so within the bounds recognized in *Baxter v. Montana* and professional practice standards.

Enclosed please find a copy of the Board of Medical Examiners position statement. If you would like more information or resources to best support your patients at the end-of-life, please contact Compassion & Choices' End-of-Life Consultation program at 800.247.7421.

Sincerely,

Doctors:

George Risi, M.D.

Stephen Speckart, M.D.

[1] Baxter v. State of Montana, 354 Mont. 234, 224 P.3d 1211(2009).
[2] Montana Board of Medical Examiners Position on Aid in Dying.

From: Gabor Benda [mailto:gabendamd@yahoo.com]
Sent: Wednesday, March 14, 2012 7:49 PM
To: Marquand, Ian
Cc: Connor, Maggie; DLI BSD Medical Examiners; bradley@montanansagainstassistedsuicide.org
Subject: Postion Statement 20

Dear Sirs,

I am writing to implore you to remove your position statement regarding the physician assisted suicide status in Montana. With this statement, you are suggesting that this procedure is already legal, and perhaps even endorsed by the Board. I was appalled to receive a letter just last week from 2 "Physicians" clearly recruited by the Compassion & Caring group, who quoted your position statement, and reassured the physicians of Montana, that they are on solid ground to proceed with physician assisted suicide requests. Please do not be an accomplice in this arena in denegrating our noble profession to the level of compromising the special nature of a human life. Physicians should not be participating in life ending procedures anywhere, let alone in our fine state of Montana, and I am dismayed to see a special interest group manipulating our state's Medical Board.

I am a Board Certified Family Medicine physician here in Bozeman, MT since 1989, and I know that the bulk of my colleages here would agree with my position. Please retract your position statement, and help us instead to preserve the dignity of our profession.

Sincerely,

Gabor Benda, MD

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gabendamd@yahoo.com